CENTERS FOR NEDICARE & NEDICALD SERVICES  OMB NO. 0938-093  AND PLAN OF CORRECTION  AND PROVIDE AND PROVIDE AND PROVIDE OR SUPPLIES  SPRING CITY CARE AND RENABILITATION CENTER  SPRING CITY CARE AND
The facility must provide for an ongoing program of activities designed to meet in excertance with the comprehensive assessment, the facility failed to honor activity preferences for 1 resident (#2) of 1 resident reviewed for activities of 30 residents reviewed.  The findings included:  Modical record review revealed Realdent #2 was edmitted to the facility on 925/08 with diagnoses including Ambiley State, Depreteined Disorder, Hemiplegia, Subdural Hemorrhage, Emphysiems, Osleosathrosis, John Stiffness, and Convulsions, Medical record review of the annual Minimum Data Set (MDS), Preferences for Coustomary Routers to resident to inject to put the findings included:  Modical record review of the annual Minimum Data Set (MDS), Preferences for Coustomary Routers to resident to regions services, and provide to get fresh in when the injection and provide to the must, somewhat important to listen to the must, somewhat important to lesten to the must, somewhat important to lesten to the must, somewhat important to reflect the word MDS dated 9/23/16  Modical record review of MDS dated 9/23/16
GENTERS FOR MEDICARE 8, MEDICALD SERVICES AND PLAN OF CORRECTION AND PROVIDER OR SUPPLIER  SPRING CITY CARE AND REHABILITATION CENTER  SUMMANY STYLEMENT OF PROPERTY TAG  SUMMANY STREET SPRING CITY. TO 37381  PRETTY DATES, STREET SPRING CORRECTION TAG  PROVIDERS PLAN OF CORRECTION TAG  PROVIDED STREET ADDRESS, CITY, STATE, ZIP CODE  33 HINCH STREET SPRING CITY. TO 37381  PROVIDED STREET ADDRESS, CITY, STATE, ZIP CODE  33 HINCH STREET SPRING CITY. TO 37381  PROVIDED STREET ADDRESS, CITY, STATE, ZIP CODE  33 HINCH STREET SPRING CITY. TO 37381  PROVIDED STREET ADDRESS, CITY, STATE, ZIP CODE  33 HINCH STREET SPRING CITY. TO 37381  PROVIDED CORRECTION TAG  FOR AUTHOR TAG  SUMMANY STYLEMENT OF CORRECTION TAG  FOR AUTHOR TAG  STREET ADDRESS, CITY, STATE, ZIP CODE  33 HINCH STREET SPRING CITY. TO 37381  1 What corrective action(s) will be accomplished for those residents  property in CARCHARD REMAINS OF CORRECTION TAG  1. What corrective action(s) will be accomplished for those residents from the deficient provided by the deficient provided by the deficient provided by the deficient provided by the same
CENTERS FOR MEDICARE 8, MEDICADS SERVICES  SAME NO. 0938-039  AND PLAN OF OGRECTION  ARME OF PROVIDER OR SUPPLIER  SPRING CITY CARE AND REHABILITATION CENTER  SPRING CITY CARE AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  331 HINCH STREET  SPRING CITY CARE AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  331 HINCH STREET  SPRING CITY CARE AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  331 HINCH STREET  SPRING CITY THE STABS  FROM CORRECTION MUST SEE PRECEDED BY FULL REGULATORY OR LOC IDENTIFYING UNFORMATION)  FOOD  INITIAL COMMENTS  FOOD  INITIAL COMMENTS  FOOD  Amended 2567 11/8/16 to reflect removal of F278.  F 248  483.15(f)(1) ACTIVITIES MEET F278  F 248  The facility must provide for an ongoing program of activities designed to meet in accordance with the comprehensive assessment, the interests and the physical, mental, and psychocecoid well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to incorr activity preferences or 1 resident (#2) of 1 resident reviewed.  The findings included:  Medical record review revealed Resident #2 was seminated to the facility of size of the fac
CENTERS FOR MEDICARE & MEDICAD SERVICES  OMB NO. 0938-039  AND PLAN OF OBSCIENCIES  OMB NO. 0938-039  (X1) PROVIDER ON SUPPLIER  AND PLAN OF CORRECTION  (X4) DATE SURVEY COMPLETED  AND PLAN OF ORRECTION  (X4) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X5) DATE SURVEY COMPLETED  (X6) DESCRIPTION NUMBER  STREET ADDRESS, CITY, STATE, ZIP CODE 331 HINCH STREET SPRING CITY CARE AND REHABILITATION CENTER  (X4) DATE SURVEY COMPLETED  (X6) DATE
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CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION  (X2) PROVIDER SUPPLIER  (X3) DATE SURVEY COMPLETED  A BUILDING A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 331 HINCH STREET SPRING CITY CARE AND REHABILITATION CENTER  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FOUND  Amended 2567 11/8/16 to reflect removal of F278.  F 248 483.16(f)(1) ACTIVITIES MEET SSED INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet; in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being  FORM ADPROVEE CMB NO. 0938-039  (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED  (X4) ID PREFIX 10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CONFISION)  FROM 11. What corrective action(s) will be accomplished for those residents  12. What corrective action(s) will be accomplished for those residents  13. What corrective action(s) will be accomplished for those residents  14. What corrective action(s) will be accomplished for those residents  15. What corrective action(s) will be accomplished for those residents  16. What corrective action(s) will be accomplished for those residents  17. What corrective action(s) will be accomplished for those residents  18. What corrective action(s) will be accomplished for those residents  18. What corrective action(s) will be accomplished for those residents  18. What corrective action(s) will be accomplished for those residents  18. What corrective action(s) will be accomplished for those residents  19. What corrective action(s) will be accomplished for those residents  19. What corrective action(s) will be accomplished for those residents  19. What corrective action(s) will be accomplished for those residents  19. What corrective action(s) will be accomplished for those residents  19. What corrective action(s) will be accomplished for those residents  19. What corrective action(
CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:  445209  B. WING  NAME OF PROVIDER OR SUPPLIER  SPRING CITY CARE AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES FREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG  FROM SUMMARY STATEMENT OF DEFICIENCIES FREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG  FOOD  INITIAL COMMENTS  FOOD  Amended 2567 11/8/16 to reflect removal of F278.  F 248  483.15(f)(1) ACTIVITIES MEET  STREET ADDRESS, CITY, STATE, ZIP CODE  131 HINCH STREET SPRING CITY, TN 37381  F 248  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  1. What corrective action(s) will be accomplished for those residents F 248 F 548 F 11/18/16 F 11/18/16 F 11/18/16 F 11/18/16 F 11/18/16 F 11/18/16
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PRINTED: 11/08/201

Any detections statement anding with an asterisk (\*) denotes a deficiency which the inalitution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclossable 90 days following the date of survey whether or not a plan of correction is provided. For hursing homes, the above findings and plane of correction are disclossable 14 descentions are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Frevious Versions Obsolete

Event (D; E7tL11

Facility IO: TN7203

If continuation sheet Page 1 of 7

If continuation sheet Page 2 of 7

CENTE STATEMEN	TMENT OF HEALTH RS FOR MEDICARE TOF DEFICIENCIES	<u>: &amp; MEDIÒ</u> A	ND SERVICES	1		FORM	); 11/08/20 MAPPROVE ); 0938-031
AND FLAN (	OF CORRECTION	IDENTIFI	CATION NUMBER;		PLE CONSTRUCTION	(X3) DA1	TE SURVEY
NAMEOC	PROVIDER OR SUPPLIER		445209	B. WING	· · · · · · · · · · · · · · · · · · ·	10	/12/2016
	CITY CARE AND REP  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR LE	TEMENT OF DE	EFICIENCIES	1.	STREET ADDRESS, CITY, STATE, ZIP CODE  331 HINCH STREET  SPRING CITY, TN 37381  PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROPERCIENCY)	ON LD BE	COMPLETION DATE
	Continued From parevealed the resider indicating the resider indicating the resider cognitive skills, total sometimes underste adequately to simple Medical record revise Life Lifestyle Review Resident #2 enjoyed services, group, and Review of the August activity calendars reservices were provided in September revealed cooking/ for times in August and Medical record review Participation Log for revealed Resident #2 activities.  Observation revealed bed in his room at the 10:00 AM, 12:00 PM, 8:00 AM, 8:45 AM, 9:10/12/18 at 7:49 AM, 1:05 PM.  Interview with the Ac at 10:45 AM, in the cat the resident had not attend group activities services or cooking/finterview confirmed the provided any out or months.	nt scored; a straint had selve int had selve int had selve int had selve int dependence of the Any deled 1/e/ I inspiration I cooking/for a looking/for stand Septe vealed group in the and selve interest	arely impaired on for bathing, and responded imminication.  Inuel Quality of 16 revealed alfreligious od activities.  In August and 8 refreciew sere provided 3 september 2016.  It by Daily September 2016.  It by Daily September 2016 at 10:00 AM; 10/11/16 at 10:00 AM; 10:06 AM, and	F 248		nary each o ses the cur:	

Facility ID: TN7203

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUM.	AN SERVICES				PRINTEE	): 11/08/2016 I APPROVED
STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDI	ER/SUPPLIER/CUA CATION NUMBER:	(X2) MUL A. BUILDI	TIPLI	e coustruction	OMB NO	), 0938-039 TE SURVEY MPLETED
	<u> </u>		445209	B. WING			ŀ	
NAME OF	PROVIDER OR SUPPLIER		!			TREET ADDRESS, CITY, STATE, ZIP CODE		/12/2016
SPRING	CITY CARE AND REH		<u> </u>		33	31 HINCH STREET PRING CITY, TN 37381		
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F 279 F 279 SS≃D	483,20(d), 483,20(k)	)(1) DEVEL CARE PLA 19 results of nd revise th	INS	F 27		accomplished for those reside found to have been affected I the deficient practice: Reside 7's care plan reviewed and	ents Py nt#	11/18/16
	The facility must develon for each resider objectives and timete medical, nursing, an needs that are identical assessment.	it that indiu ables to me d montaller	des measurable et à residents	-		updated on October 11, 2016 October 12, 2016 to reflect resident's current status.  2. How will you identify other	:	
	The care plan must of to be furnished to att to be furnished to att highest practicable personal well-be \$483.25; and any ser be required under §4 due to the resident's \$483.10, including thunder §483.10(b)(4).	ain or main hysical, me ing as requivices that to 83.25 but a exercise of e right to re	tain the residents ental, and ired under would otherwise ere not provided			residents having the potential be affected by the same defici practice and what corrective action will be taken: Minimum Data Set (MDS) nurses, Director Nursing (DON), Assistant Nursing Director (ADON), Staff Development Coordinator (SDE	ent Pr	
	This REQUIREMENT by: Based on medical re and interview, the factomprohensive plant of resident reviewed for residents reviewed.  The findings included	cord review flity failed to of care for the or hemodia	/, observation, o provide a f resident (#7) of lysis care of 30		3	to complete 100% audit of remaining residents' care plan and medical record to ensure that a comprehensive care plan has been developed by November 16, 2016.		
},	Viedical record review admitted to the facility with diagnoses includ and Stage Renal Disc	/ on Septen inα Anemie	nbor 23, 2015,			place or what systemic changes will you make to ensure that th		
3M CMS-250)	7(02-02) Previous Versions Ob	Bolete	Event ID: 6711,11	F	ecility	PD; TN7203 If continu	ation sheet	Page 3 of 7

DEPAR	RTMENT OF HEALTH	AND HUMA	N BERVICES	,			PRINTE	ED: 11/08/2016
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AND PLAN	OF CORRECTION	IDENTIFIC	R/SUPPLIER/CLIA CATION NUMBER			CONSTRUCTION	(X3) C	PATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER		<del></del>	<del></del>		REET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	0/12/2016
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F 279	Continued From pag	0				deficient practice does not re	ecur:	<del>-</del>
,	Anxiety, and Depres	ge 3 Je 3	1	F 2	79	All licensed nurses will be re-	•	i
	1	i i	•			educated on the developmen		•
	Medical record revie	w of the nur	sing admission			and updating of resident's	•	ĺ
	venous catheter (CV	a the reside (C) for helma	nt nad a central			Interim Care Plan, as well as,	the i	
		ŀ	1			Complete Care Plan by Nove		1
	Medical record revie Care Plan dated 6/2	W of the Col	Tiprehensive			11, 2016. A Care Plan		} _
	Potential for complic	ations refeté	id to		-	Conference will be conducted	1	
	hemodialysis" Cor approaches/interven	tinned revie	wirevealed the	,	-	guarterly with the resident a		
	I brannald for rife test	ient's CVC	incinde aux cate		1	or POA/Family and the		
	access,	:	,			Interdisciplinary team to		
	Observation of Resid	ient#7 on 1	0/32/18 at a∵45			coordinate resident's		
,	i www. ievealed a white	AYA draech	والمناح أجام ومعارما	ļ i		comprehensive care plan and		1 .
	are or are CAC St tu	e nghi shoul	der area.		1	update as needed.		
	Interview with Licens	ed Practical	Nurse (LPN) #3		-	4. How the corrective action(s)	will	
	on 10/12/16 at 9:00 / revealed LPN #3 rec	AND IN the ma	awalia	_		be monitored to ensure the		1 1
	I ALAAAMINA DITEL LIMBILIA		DOMESTA TLA	; -		deficient practice will not	:	
	LILLER AND A COUNTY COLOR	(esiden!'#7'	보수하다 지역하 선생 기			recur; i.e., what quality assura	ince :	
ı	not include dressing	•				program will be put into plac	e:	
	Interview with the Dir	ector of Nur	se's on 10/11/16			20% random audit of Care Pi	ากร	
i	from admission 9/23/	illerence froc 16 to the bro	offirmed,			will be completed by	-	
ļ	TASMACHT HAN SEEMEN	ar acmodici	(Bio 000000 )			Interdîsciplinary Team Monda	ay- į	]
	the comprehensive of for the CVC.	are plan did	not include care		1;	Friday for 4 weeks, then 3 tim	ies İ	}
			r			weekly for 4 weeks, then wee	:ƙly	
F 312	483.25(a)(3) ADL CA	DC DD OLAR				for 4 weeks, or until 100%		
SS=D	483.25(a)(3) ADL CA DEPENDENT RESID	ENTS	EU FOR	F 31:	2   j	compliance is maintained for		11/18/16
. ]		' !				weeks. Results of audits will I	je ¦	
	A resident who is una daily living receives th	de lo caity : Die lo caity :	Out activities of			reported to the QAPI commit	tee :	
						, monthly.	:	
км СМ\$-25	37(02-99) Previous Vorsions Ob	sciete	Event IO: E7(L1)	F	acility	ID: TN7203 If continu	ation she	et Page 4 of 7

	TMENT OF HEALTH	& MEDIOA	ND SERVICES				FORM	D: 11/08/2016 MAPPROVED
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE IDENTIFE	ER/SUPPLIER/CLIA CATION NUMBER;	(X2) MUI A. BUILE	TIPLE	CONSTRUCTION	(X3) DA	). 0938-0391 TE SURVEY MPLETED
NAME OF	PROVIDER OR SUPPLIER		444208	B. WING			1	140.00.0
	CITY CARE AND REH	ABILITATIO	N CENTER		334	REET ADDRESS, CITY, STATE, ZIP CODE 1 HINCH STREET 'RING CITY, TN 37381	<u> </u>	/12/2016
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F 312	Continued From page maintain good nutrit and oral hygierre.  This REQUIREMEN by: Based on medical reand interview, the far showers for 1 reside reviewed for activity residents reviewed.  The findings included Medical record reviewed for activity residents reviewed.  The findings included Medical record reviewed for activity residents reviewed.  Medical record reviewed admitted to the facility including Anxiety Statemiplegia, Subdurated Osteoarthrosis, Joint Medical record reviewed dated 9/23/16 revealed adequated communication.  Medical record review Care Plan dated 1/7/revealed, "resident Living] self care deficiency of the Bathing through 10/12/16 review of the Bathing through 10/12/16 review on 8/19/16 are Observation with Lice	T is not insecond review of the Condition of the Conditio	et as evidenced  w, observation to provide residents g needs of 30  Resident #2 was 8 with diagnoses ave Disorder, age, Emphysema, and Convulsions, Im Data Set fent scored a 7 on thad severely dependent for others and direct  mprehensive sed on 9/26/16 ctivities of Daily [times] week"  ted 8/1/16 ssident received a	F3		1. What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice: Resident 2 was asked preference between a baths or shower and stated "don't want either, but a bath." POA contacted by Director of Nursing (DON) and she stated whatever Resident#2 prefers shis okay with. Care plan updated to reflect resident choice, on November 4, 2016.  2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents, with a BIMS less than 8, ADL care plan will be reviewed for bathin preference. Responsible party of Power of Attorney will be contacted to update bathing preference on ADL care plan by November 14, 2016. Residents with BIMS 8 or above will be	nts  V  t#  en  ne  ne  no  nt	11/18/16
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	#1 on 10/12/16 at 1: fying on the bed, positiving on the bed, positiving on the bed, positiving to get up and received interview with the Di 10/12/16 at 1:25 PM revealed residents was week and confirmer received showers two	40 PM revisitioned on the sitioned on the sitioned on the sitioned on the early of the sitioned on the sitione	the right side.  10/12/16 at 12:44 esident would like esident would like  ursing (DON) on ence room, sive showers twice t.#2 had not  IRATE/ACCESSIB  al records on each espted professional e complete; accessible; and  a sufficient ent; a record of the m of care and f.any ted by the State; et as evidenced w and interview, escullate medical	FS		interviewed to determine bathing preference and caplans will be updated by November 14, 2016.  3. What measure will be put place or what systemic chawill you make to ensure the deficient practice does not Education to licensed nursicertified nursing assistants residents bathing preferer November 11, 2016. Audit ADL bathing report Monda Friday for 2 weeks, 3 times week for 4 weeks, weekly weeks, and then monthly formonths.  4. How the corrective action (be monitored to ensure the deficient practice will not recur; i.e., what quality assist program will be put into pland and and and and and and and and and	into anges nat the trecur ses and tof ay- for 3 for 3 s) will e urance t s, 3 weekly	
	The findings included	નં			} ;		киу	
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NAME OF	PROVIDER OR BUPPLIER		<del>'</del>	1	STRELT ADDRESS, GITY, STATE, ZIP CODE	10	/12/2016
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	<u> </u>	<u> </u>			DEFICIENCY)	PRIATE	DATE
F 514	Continued From pag				for 3 months. Results of audit		<del> </del>
	Conditional Light being	je o		F 31			}
İ	Medical record revie	w of the Adi	nission Record	•	will be reported to the QAPI		
	Face Sheet revealed	í Resident#	142 was		committee monthly.		
	admitted to the facili	ty on 10/6/16	3_v∤ith diagnoses				
	including Urinary Tra of Sacral Region Sta	ict Infection	Pressure Ulcer				
	Spinal Stenosis.	ige a, MilXie	ly pisorder, and		,		]
		i	i i	F 51	1. What corrective action(s) will	ha	
	Medical record revie	w of the Bra	den Scale for	FQ1	accomplished for those reside		11/16/16
i	Predicting Pressure revealed the residen	Sore Risk di	sted 10/1/18				1
	pressure sores.	i r made er litile	I HSK fOF		found to have been affected	•	1
	Modforton	· · · · · · · · · · · · · · · · · · ·	1		the deficient practice: Reside	πt	}
	Medical record review	w of the Nur	noisaimbA gida	i .	#142 admission assessment		;
	Skin Evaluation date Decublus on buttoch	(Q. Méscure	in law-	,	reviewed and a note has been	1	<b>i</b>
Į	fabbloximatel/13.2 d	m [centimet	eral x lhvi 4 cm v	]	made to reflect that admissio	n	1
	0.3 cm"			j	assessment including Braden		1
]	Interview with the no	 	.)		Scale and Skin assessment we	ro	
j	Interview with the Dir at 8:45 AM, in the Ad	minishators	Sing on 10/12/16		la de la companya de		
	are erectionic Medica	ii record:wa:	atempositor		not completed on 10/1/16, bu		1 !
	QUO to the Nursing Ad	imission Ski	in Evaluation		upon admission on 10/8/2016	j-	ļ
	and the Braden Scale Sore Risk both wera	e for Predict	ng Pressure		10/9/2016.	1	1
	resident was not adm	uated Turiyi litted to the t	ecitiv vati		2 Venuelland is at	]	
	10/8/16.		- Party with		2. How will you identify other	•	
		į	<u>}</u>		residents having the potential		}
		ì			be affected by the same defici	ent	
		•	·		practice and what corrective	ļ	
		<b>.</b>	, .		action will be taken: Current		
Ì		į	1		residents admission assessme	nts	
					were reviewed for accurate da		
		į			by Director of Nursing (DON) (		1
		i	:		October 28, 2016. Any issues	"'	
[		!	[		identified were corrected.	1	
RM CMS-258	7(02-99) Previous Versions Ob		Event ID: E71L11	<del>-</del>			
			( event (D) E/11/77	F	sellly ID: TN7209 If continu	ation shee	t Page 7 of 7

emetate Ald Cua	nt of deficiencies of correction	(X1) PROVIDER/SUPPLI IDENTIFICATION N	ER/CHA JMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE	APPRO
		TN7208	<u>-</u>	B. WING		1	12/201
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS. CITY,	STATE, ZIP CODE	1 120	IN EV 1
SPRING	CITY CARE AND RE	HABILITATION CE	331 HINCH SPRING CI	STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICENCIE Y MUST BE PRECEDED BY SCIDENTIFYING INFORM	\$	ło Pripix TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	h 모드	COMP DAT
N 001	1200-8-6 Initial Cor	mments		F 514	3. What measure will be put in	ito	-
		<u> </u>	1		place or what systemic chan	ges i	
ĺ	This Rule is not m	et as evidenced by			will you make to ensure that	t the	
	Outside the licensur	e survey conducted o	on .		deficient practice does not r		
	keuspilitation Cent	i6, at Spring City Car er, no deficiencies w	ere cited	i	Education to licensed nurses		
Ī	under 1200-8-6, \$6	andards for Nursing	Homes.		Staff Development Coordina		
]	•	' '	j		SDC), (DON), or Assistant Dir		
Ì		i i	ļ		of Nursing (ADON) on checki		
1		, !			the dates on Admission	5	
		<b>;</b>		1	Assessments prior to comple	ting :	
ĺ		! !	•		for accurate dates, also before		
		, i			signing off each section of		
		} }		ł	assessment to ensure the cor	rect	
		'j '			date is noted by November 1		
				i	2016. New admission charts		
1				ĺ	assessments will be reviewed		
}				•	upon admission for accurate		
İ		, ;		{	dates noted. If dates are not		
			1	-	entered correctly admitting n		
]		,			will make a note stating wher		
					assessment was completed.		
		•			audit the dates on admission	1 1	
		1			readmission assessments dail	1 1	
1		i ;	[	1	, clinical meeting Monday thru		
		!		-	Friday Will audit 10 randon		
		, ;			assessments Monday thru Frid	1	
			-		for 2 weeks, then 5 random	.	
]		:	}		assessments 3 times a week fo	or 4	
n of Hea	Ith Care Facilities						
D ATORY سرر	RECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTA	Tive's eignat		Tiftle		(4) DATE
FORM					Administrator	ň	1 1-7

Division	of Health Care Fac	Illikas /				PRINTED: 11/08/2016
I STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER	SUPPLIER/CLIA TON NUMBER:	(X2) MULTIPI	E CONSTRUCTION	FORM APPROVED (X3) DATE SURVEY
ĺ		<u> </u>	  -			COMPLETED
NAME OF	PROVIDER OR SUPPLIER	TN7203	<del> </del>	B. WING		10/12/2016
		,	STREET AL	ODRESS, CITY, S CH STREET	STATE, ZIP CODE	
	CITY CARE AND REH		SPRING	CITY, TN 379	361	
(X4)  D PREFIX TAG	Summary Sta (Each deficiency Regulatory or L	TEMENT OF DEFIC MUST BE PRECE SCIDENTIPYING IN	TER BY EIK I	ID PREPIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE APPROVIDERS OF THE AP	DRE CONTINUE I
N 001	This Rule is not me During the licensure October 10-12, 2816 Rehabilitation Cente under 1200-8-6, Sta	t as evidenced survey condu s, at 9pring Cil	bled on ly Care and les were cited	F 514	weeks, then weekly for 4 weeks. Random audits will be done monthly.  4. How the corrective action(s) to be monitored to ensure the deficient practice will not recur; i.e., what quality assurate program will be put into place Will audit the dates on admission assessments daily in clinical meeting Mondathru Friday. If dates are not entered correctly admitting nowill make a note stating when assessment was completed. When a sudit 10 random assessments Monday thru Friday for 2 weeks then 5 random assessments 3 times a week for 4 weeks, then weekly for 4 weeks. Random audits will be done monthly. Audit findings will be reported QAPI committee monthly.	will nce e: sion ay urse the Vill
ision of Heal	th Care Facilities				<u> </u>	
·	RECTOR'S OR PROVIDER	ALL -C	SENTATIVE'S SIGNA	TURE	A/ TITLE	(X8) DATE
NE FORM			454	F 571	LIII	1 - 17-16 I continuation sheet 1 of 1